PRINTED: 05/20/2009 FORM APPROVED

TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: HFD03-0009		MBER:	A. BUILDING B. WING		(CG) DATE 6 COMPLI		
AME OF F	ROYDER OR SUPPLIER				TATE, ZIP CODE		
VHOLIS	TIC 02		WASHING	RENCE STR TON, DC 20	KERI, ME 1017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PRÉFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEPICIENCY)	N SHOULD BE APPROPRIATE	(AS) COMPLET DATE
1 000	INITIAL COMMENT	rs		1000			
	2009 through June initiated using the fit random sample of it a resident population disabilities.	was conducted from 12, 2009. The survey production to the survey production of seven makes with survey were based of seven makes of seven makes of seven makes of seven pages of seven pag	y was roosse. A sted from th various		GOVERNMENT OF THE	- - -	
,	observations, interv with staff in the hon as well as a review	survey were passed or riews with clients, into ne and at three day p of client and adminis neident and investiga	erviews erograms, etrative		825 NORTH CADITO	E DISTRICT OF CO NT OF HEALTH ION ADMINISTRA ST., N.E., 2ND FL DN, D.C. 20002	LUMBIA ION OOR
1 056	3502.14 MEAL SEF	RVICE / DINING ARE	EAS	I 058			
	preparation and ser cars of equipment,	train staff in the stor rving of food, the clea and food preparation conditions at all time	ining and		5ee w 45 4	}	
	Based on observati GHRMP failed to er food in sanitary con	met as evidenced by lone and interview, the reure that each staff iditions at all times for realding in the GHRN #4, #5, #6, and #7)	prepared or seven				
	The finding includes	0 ;					
	was observed thaw with warm water rul Mental Retardation made aware this ist water from warm to continued to be that	at 3:14 PM, a pack oring out inside the kitchning over it. The Qui Professional (QMRF sue an immediately to cold while the chickly wed out inside the alled that staff should it.	chen sink lalified) was umed the len len len len len len len len len le			·	

Health Regulation Administration

PRINTED: 06/20/2009 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (A2) DATE BURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A RUILDING B. WING HFD03-0009 06/12/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 1226 LAWRENCE STREET, NE WASHINGTON, DC 20017 WHOLISTIC 02 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (0(5) COMPLETE DATE D (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 1056 Continued From page 1 1056 cold water over the chicken. There was no evidence that the GHMRP maintained a sanitary environment to avoid sources and transmission of infection. 091 3604.2 HOUSEKEEPING 1001 Housekeeping and maintanance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the GHRMP failed to maintain the interior and exterior of the GHMRP in a safe, clean, orderly, attractive, and sanitary manner. The findings include: Observation and Interview with the House Manager during the environmental walk through on June 12, 2009, beginning at 12:22 PM, revealed the following. 413/04 1. The front left and rear eyes located on the New stone delivered kitchen stove was observed to be inoperable. on 6/13/09 Interview with the House Manager revealed that they purchased a new stove the day before the surveyors arrived. 12ail has been treshtened 6/13/09 2. The handrall leading from the main hall way to the basement was observed to loose. Screen has been replaced 6/12/09 3. The back door screen was observed to be torn.

Health Regulation Administration

PRINTED: 08/20/2009 FORM APPROVED

AND PLAN	ANOLISTIC 02 1226 LAV		CLIA (PE) MULTI ER: A BUILDU B. WING	TIPLE CONSTRUCTION NG	COMP	(XS) DATE SURVEY COMPLETED	
NAME OF P			TREET ADDRESS, CITY,	STATE VID AADE	00/	12/2009	
			226 LAWRENCE ST /ASHINGTON, DC	REET. NE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUI SCIDENTIFYING INFORMATIC	ID PREFIX TAG	PROVIDERS PLAN OF CI (BACH CORRECTIVE ACTIC CROSS-REPERENCED TO THE DRFICIENCY)	ON SHOULD BE EAPPROPRIATE	COMPLETE DATE	
1 135	Continued From pa	ge 2	1 135				
1 135	3505.5 FIRE SAFE	ΤΥ	1 136				
	Each CUMBB about			see w440			
	order to test the effe four (4) times a year	conduct simulated fire activeness of the plan a for each shift.	driks in i t leagt	w 441	·		
	Based on interview of GHMRP falled to he on all shifts for seve	met as evidenced by: and record review, the ild evacuation drills qua n of seven residents re ta #1, #2, #3, #4, #5, #6	sidina .				
1	The findings include						
	interview with Qualifi Professional (QMRF staffing schedule rev designated shifts (8:	9, at approximately 11;3 ied Mantal Retardation b) and review of the wee realed that there were to 00 AM-4:00 PM; 4:00 2:00 AM - 8:00 AM) sev	okly hrae				
	(4) a year for each at 2009. Review of the 10, 2009, beginning a poly two drills had be shift (on January 4, 2 January 5, 2009, at 6 fire drills revealed the June 2008 through A to 12 AM shift, Inten	I fire drills at least four thift from June 2008 to he fire drill log book on Just 11:43 AM, revealed the held during the more 2009, at 9:45 AM and BAM). Further review of the and the with the QMRP and drills were not conducted the drills were not conducted the drills were not conducted the drills were not conducted.	Agy ne hat ning of the orn 4 PM				
	Alen see Federal	Deficiency Citation W44	.				

Jeelan Medinedon Wowilliedesion

STATE FORM

CENTE	RS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES			FOR	D: 08/20/20/ M APPROVE D: 0938-039
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/QUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G112	B. WING			40000
NAME OF F	TOVIDER OR SUPPLIER TTC 02		12	ET ADDRESS, GITY, STATE, ZIP (MI LAWRENCE STREET, NE		12/2009
(X4) ID PREFIX TAG	(EACH DEFICIENTS	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE
W 000	INITIAL COMMEN	TS	W 000	-		
	 a, 2009 through Ju- initiated using the fi- tandom sample of a resident population disabilities. The findings of the	rvey was conducted from June no 12, 2009. The survey was undamental survey process. A four clients was selected from on of seven males with various survey were based on				
	with staff in the hon as well as a review records, including in reports.	news with clients, interviews ne and at three day programs, of client and administrative incident and investigation	W 154			
	CLIENTS .	vo evidence that all alleged				
_	Based on interview : failed to thoroughly (not met as evidenced by: and record review, the facility investigate an injury of origin a included in the sample,				
-	The finding includes	:				
i t	M's nursing assessing assessing assessing the section, on Septivas noted with a bruwas transported to the urther evaluation.	tt 12:01 PM, raview of Client ment dated October 24, 2009 Health Status' section. Under amber 13, 2008, Client #4 ilse on the left shoulder and he Emergency Room (ER) for the ER discharge report as diagnosed with a		•		
1	contusion to the left of 2:10 PM, inquiry wa	shoulder. At approximately us made regarding the		TITLE		

Any deficiency absternent ending with an asteriak (*) denotes a deficiency which the institution may be extuned from correcting providing it is clatermined that other sefeguards provide sufficient protection to the patients. (See instructions.) Except for nursing horses, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing horses, the above findings and plans of correction are disclosable 14 lays following the date these documents are made svellable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES					06/20/2009
	RS FOR MEDICARE	& MEDICAID SERVICES					MAPPROVED 0. 0938-0381
AND PLAN	OF CORRECTION	(X1) PROVIDER/GUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) I		TIPLE CONSTRUCTION	(23) DATE SURVEY COMPLETED	
		09G112	8. WI	NG_			
WHOLIS	PROVIDER OR SUPPLIER 1710 02		<u> </u>	1	REET ADDRESS, CITY, STATE, ZP CODE 1228 LAWRENCE STREET, NE WASHINGTON, DC 20017	1 09/1	12/200 8
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREF	DX	FROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION 8HO CROSS-REPERENCED TO THE APPR DEFICIENCY)	ULDEE	COMPLETION DATE
·	incident report for the Mental Retardation provided the survey which documented with discoloration or Further interview with discoloration or Further interview with discoloration or Further interview with discoloration or Investigated. The investigated. The investigated with discoloration of the shoulder ER for further evaluational interviews have sustained the investigation recommend the investigation recommend the investigation recommend the investigation recommend the investigation and interviews report. There was nefacility had sought to nature of the injury. 463,430(a) QUALIFI RETARDATION PROBLEM COORDINATE INTERVIEW INTERV	is injury. The Qualified Professional (QMRP) or with the incident report, that Client #4 was discovered in his left shoulder. It the QMRP revealed that the left shoulder was vastigation report dated it, revealed that Client #4 was location on his left upper arm by staff and was taken to the ation. Further review of the mended the facility to continue ad. There was no evidence asked how the client might night to the left shoulder stc.). There were no indicated in the investigative of evidence whether the indetermine the source or evidence whether the determine the source or exidence whether the reatment program must be ad and monitored by a relation professional.	W 1			l. (1/09, new vestigation	LS.
				- }			

CENT	ERS FOR MEDICARE	HAND HUMAN SERVICES BANDICAID SERVICES					FORI	D: 08/20/2009 M APPROVED D: 0938-038/
STATEMEI AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A. Bi		TIPLE CONSTR NO	(X3) DATE SURVEY COMPLETED		
		09G112	B. W	ING_				44.
WHOLI				, ,	1226 LAWREN	S, CITY, STATE, ZIP CO ICE STREET, NE DN, DC 20017		12/2009
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W 159	The findings include	ž.	W	159				
	provided opportuniti	d to ensure that clients were les for making choices as a nagement. [See W247]			See	w 247		
	2. The QMRP falled drille were conducte W440]	of to ensure that fire evaluation of quarterly on all shifts. [See			SCE	w440		
	3. The QMRP falled conducted under value	to ensure fire drills were ried conditions.[See W441]			see	W441		}
	4. The QMRP failed competency in the in support plans. [See	i to ensure staff demonstrated inplementation of the behavior W193]			See	w193		
	furnished and maint	to ensure the facility alhed in good repair, a lest strup for Client #2. [See			See V	1436		
W 193	483.430(e)(3) STAF	F TRAINING PROGRAM	W 1	93				
	techniques necessar	demonstrate the skills and by to administer interventions repriate behavior of clients.					ĺ	
	Based on observation record verification, the demonstrate competed of the behavior support.	not met as evidenced by: ns, staff interviews and se facility staff falled to ency in the implementation ort plans (BSPs), for one of semple. (Clients #1)			·			
	The findings include:							
	1. The facility failed t Client #1's BSP as ex	to ensure staff implemented						

DEPARTMENT OF HEALTH AND HUMAN SERVICES . CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA

PRINTED: 06/20/2009 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICA		(X1) PROVIDER/GUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE 5	
		09G112	B. WING		06/1	2/2009
NAME OF F	PROVIDER OR SUPPLIER TTC 02		13	EET ADDRESS, CITY, STATE, ZIP C 236 LAWRENCE STREET, NE /ASHINGTON, DC 20017	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FRÖVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XS) COMPLETION DAYE
W 193	Cilent #1 stopped I began to stare at the Manager (HM) ask client did not response the surveyor therefore, the surveyor's chirt unterproved each people or staff is as behaviors." There was no evide acting as the 1:1 stof Client #1's behaviors. 2. On June 9, 2004 observed to snatch At 6:16 PM, the Hoto redirect Client #1 As a result, Client # Further observation attampted to enatch throughout the enatch throughout the enatch conserved without his classroom with observed without his 12:30 PM, during it.	on June 9, 2009, at 5:20 PM, coking at his magazine and he surveyor. The House and continued to stare, veyor said hello. At 5:26 PM, the surveyor's shirt and was the client refused. The HM in finger one by one from the dit he released his grip. at approximately 2:00 PM, deted October 1, 2008, g approached by unfamiliar in entecedent to problem ence that the HM (who was aff) made the surveyor aware vior of grabbing unfamiliar in a 6:13 PM, Client #1 was his house mate's spaghetti, use Manager (HM) attempted in from anatching food again. It grabbed the HM's face. It grabbed the HM's face.	W 193	QNRP will condition - service on behavior supportant responsibility to be at his lill conduct an in second client # 1's support plan	client #1 + plan ity and staff, also ervice	7/20/09
EN CUR-SE	87(02-00) Provious Versions	Charles Event ID: 5.NP11	Faci	ttv ID: 09@112	f continuation sheet	E Dans 4 of 13

CENTE	RS FOR MEDICARE TOF DEFICIENCIES	AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 08/20/2009 MAPPROVED): 0938-039 1
AND PLAN	OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A BU			()(3) DATE (COMPL	
		09G112	B. WII	NG_			
NAME OF I	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	06/	2/2009
WHOLIS				1	226 LAWRENCE STREET, NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECIEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D RE	COMPLETION DATE
W 247	Qualified Mental Re (QMRP) revealed the within arms length BSP confirmed that remain within arms in the evidence that stain the implementation 483.440(c)(6)(vi) INIT The individual programment, This STANDARD is Besed on observation	at 3:00 PM, interview with the tardation Professional at Client #1's 1:1 staff should the of at all times. Review of the Client #1's 1:1 should length at all times. There was iff demonstrated competency in of the client's BSP. DIVIDUAL PROGRAM PLAN am plan must include int choice and not met as evidenced by: In Interview and record	W 1	47	QMRP will schedul an in-service on cli #2's meal time pro	le ent	7/10/04
	were provided oppor as a part of their self clients included in the The finding includes: On June 9, 2009, at abserved eating a pussistance. At 6:33 if from a spout while the Review of the Occup dated August 27, 200 10:00 AM, revealed Cup with minimum as interview with the ReQualified Mental Retailed Mental Retailed	6:16 PM, Client #2 was preed dinner with total PM, Client #2 drank Padialyte e staff held the cup for him. Stional Therapy Assessment O7, on June 12 2009, at Client #2 "is able to hold his sistance from staff. gistered Nurse and the ardation Professional #2 is able to hold his cup			42's Meal time pro		

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 05/20/2009 MAPPROVED D: 0938-0301	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING	(XS) DATE	(XII) DATE SURVEY COMPLETED	
		09G112	B. WW	16	000	12/2009	
NAME OF	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD		12/2009	
WHOLIS				1228 LAWRENCE STREET, NE WASHINGTON, DC 20017	•		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	COMPLETION DATE	
W 247	Continued From pa	ge 5	W 2	247			
W 261	with drinking from h	exercise his independence is spout cup. GRAM MONITORING &	W 2				
	The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interset in the facility.			The HEC sign-In comprises of two It was an oversithe facility to no copies of the secon from the messer H folder for the mon	pages. In by He hake I page AC		
	This STANDARD is not met as evidenced by: Sased on observation, interview, and review of the Human Rights Committee (HRC) minutes, the facility failed to ensure that persons with no ownership or controlling interest in the facility consistently pericipated on this committee for three of four clients included in the sample. (Clients #1, #3, and #4) The findings include: On June 9, 2009, at 4:57 PM, Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference, revealed that Clients #1, #3, and #4 received psychotropic medications for their maladaptive behavior. 1. On June 9, 2009, at 6:08 PM, Client #1 was			Glylos, 11/10/08, 12/1 1/14/09 and 2/11/09 Tind attached copi the first and sec 12age of the HR meeting sign in 8t for the aforemental pronth s	o los, Please es of and C	7/7/09	
	to help decrease for Client #1 was observabletion 5 mg, Valpro	ste guard during dinner time d spillage. At 7:02 PM, red to received Haidol oral olo Acid 5 mi, and _ 10 mi by mouth during the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORI	D: 06/20/2009 M APPROVED D: 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE (SURVEY
		0 9 G112	B. Wi	NG_		900	12/2009
WHOLIS	PROVIDER OR SUPPLIER		<u> </u>	l '	REET ADDRESS, CITY, STATE, ZIP COD 1226 LAWRENCE STREET, NE WASHINGTON, DC 20017		12/2000
(X4) ID PREFIX TAG	I FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENT/FYING INFORMATION)	ID PREF TAG		PROVIDERS FLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD RE	COMPLETION DATE
	the Trained Medication that these medication matadaptive behavior Rights Committee (conducted on June According to the HR 2/11/09, and 11/10/2 medications and Bediet, hospital bed, at and approved. Furth corresponding signal minutes failed to evice controlling interest in This was acknowled the QMRP. 2. On June 9, 2009, observed to recalved mg, ability 10 mg, and during the medication interview with the Training the medication interview with the Training the medication interview with the Training the Human Rights Committee was conducted the Human Rights Committee was conducted to the Human Rights Committee was conducted to the minute and diet were review review of the correspatianched to the minute facility's HRC committee was an interview with the Qilling and diet were review of the correspatianched to the minute facility's HRC committee was an interview with the Qilling and diet were review of the correspatianched to the minute facility's HRC committee was an interview with the Qilling and the present. This was an interview with the Qilling and the present. This was an interview with the Qilling and the present. This was an interview with the Qilling and the present.	tration pass. Interview with toon Employee (TME) revealed one were prescribed for one. Review of the Human HRC) meeting minutes was 11, 2008 at 3:46 PM. IC minutes dated 5/20/09, 08, Client #1's psychotropic havior Support Plan (BSP), and plate guard were reviewed her review of the sture sheet attached to the dence that the facility's HRC persons with no ownership or a the facility was present. ged through interview with a 27:11 PM, Client #3 was 1 Tegretol 400 mg, Luvox 50 and Zyprexa 5 mg by mouth an administration pass. Sined Medications were laptive behaviors. Review of ommittee (HRC) meeting that on June 11, 2008 at 3:17 a HRC minutes dated. Client #3's psychotropic navior Support Plan (BSP) and approved. Further conding signature sheet the facility was oknowledged through	W:	261			

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/20/2009 MAPPROVED 0. 0938-0391
STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	AULTIPLE CONSTRUCTION VILDING	(X3) DATE (BURVEY
_		09G112	D. WI	NG	00/	12/2009
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP COI		122444
WHOLIS			· 	1226 LAWRENCE STREET, NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEPICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION)	AHOULD BE	COMPLETION DATE
	observed to receive mg, and Depakene medication administ the Trained Medication that these medication medication medication medication of the HR 2/11/08, and 12/10/0 medications and Be and diet were review review of the correct attached to the minutacility's HRC commownership or control present. This was a interview with the QI 482.480(a)(3)(iii) PH The facility must proexaminations as determinations as determinations as determinations as determined necessariour clients included.	d Luvex 50 mg, Risperdal 1 10 ml by mouth during the tration pass. Interview with the Employee (TME) revealed ons were prescribed for ors. Review of the Human HRC) meeting minutes was 11, 2008 at 3:28 PM. IC minutes dated 5/20/09, 28, Client #3's psychotropic havior Support Plan (BSP) wed and approved. Further pending signature sheet rites falled to evidence that the little included persons with no filing interest in the facility was acknowledged through MRP. IYSICIAN SERVICES vide or obtain annual physical the client that at a minimum pening laboratory armined necessary by the not met as evidenced by: and record review, the facility fine laboratory testing as ry by the physician, for one of in the sample. (Client #2)	W 3	281	review ician dentify menth.	6/26/pq
	ordered by the Prima	obtein leboratory studies as My Care Physician (PCP).				
	Review of Client #2's	physician's order (PO) from		ĺ		

PRINTED: 06/20/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE BURVEY COMPLETED A BUILDING B. WING 0**B**G112 09/12/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GODE 1226 LAWRENCE STREET, NE WHOLISTIC 02 WASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION
(BACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LBC IDENTIFYING INFORMATION) (XS) COMPLETION TAG TAG DATE W 325 Continued From page 8 W 325 October 2008 to May 2009 on June 11, 2009, at approximately 2:10 PM, revealed an order for the client to have laboratory studies for CBC and CMP every two months. There was no evidence of laboratory studies for the Client's CBC and CMP for December 2008. Interview with the Registered Nurse (RN) on June 12, 2009, at approximately 2:30 PM, confirmed that the laboratory studies were not completed as ordered. W 438 483.470(g)(2) SPACE AND EQUIPMENT W 438 The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces. and other devices identified by the Interdisciplinary team as needed by the client. The surveyor was shown monthly adaptive This STANDARD is not met as evidenced by: equipment audit street which documents cutempts Based on record review and staff interview, the facility failed to fumish and maintain in good repair, a padded pediatric chest strap for one of the four clients included in the sample. (Client made by the facility #2) inquiring about client# 21/2 The finding includes: New pediamic strap Lat least twice monthly). The Review of Client #2's medical record on June 11.

2009, at approximately 2:00 PM, revealed a

medical records review revealed a Physical Therapy (PT) 3rd quarterly report dated July 26, 2009. According to the PT 3rd quarterly report, a

disgnosis that included Cerebral Palsy. Further

recommendation was made to install a padded pediatric size chest strap to Client #2's new wheel

Facility will continue to

work on getting all adaptive equipment in a timely

Manner and will document

all efforts made

PRINTED: 08/20/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES **OMB NO. 0038-**0301 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: (XS) DATE SURVEY COMPLETED (A2) MULTIPLE CONSTRUCTION A. BUILDING B. WING 09G112 06/12/2009 NAME OF PROVIDER OR BUPPLIER STREET ADDRESS, CITY, STATE, 20 CODE 1220 LAWRENCE STREET, NE WHOLISTIC 02 WASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (209) COMPLETION (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY W 438 Continued From page 9 W 438 chair to be used for transportation only. Review of the physical therapy evaluation dated October 30, 2008 stated that the "Qualified Mental Retardation Professional (QMRP) should follow up on the chest strap to be used during transportation for added safety." Review of the 719 form dated August 12, 2008. indicated an order to install a padded pediatric size chest strap. Further review revealed a repeated 719 form dated January 4, 2009. Review of the physical therapy 1st quarterly report dated January 22, 2009 revealed another recommendation for Client #2's pediatric chest strap. Review of the sales service invoice dated April 13, 2009, confirmed delivery of Client #2 Chest strap. Interview with the QMPR on June 12, 2009, at approximately 2:45 PM, indicated that the client did not receive his chest strap in a timely manner due to delay in payment. At the time of the survey, there was no evidence that Client #2 received his chest strap for edded safety in a timely manner. W 440 483,470(I)(1) EVACUATION DRILLS W 440 CIMPP and House Manager 6/26/09 will ensure that fire Arills The facility must hold evacuation drills at least quarterly for each shift of personnel. are conducted quarterly

This STANDARD is not met as evidenced by:

shifts for seven of seven clients residing in the

facility. (Clients #1, #2, #3, #4, #5, #6, and #7)

Based on Interview and record review, the facility falled to hold evacuation drills quarterly on all

for each shift. Attached

utilized by the facility

Schedule that will be

is a copy of the the Dril

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (XS) DATE SURVEY COMPLETED A BUILDING B. WING 09G112 06/12/2000 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1228 LAWRENCE STREET, NE WHOLISTIC 02 WASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION COMPLETION DATE PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE FREFIX TAG DEFICIENCY W 440 Continued From page 10 W 440 The finding includes: On June 10, 2009, at approximately 11:30 AM. interview with Qualified Mental Retardation Professional (QMRP) and review of the weekly staffing schedule, revealed that there were three designated shifts (8:00 AM-4:00 PM; 4:00 PM-12:00 AM and 12:00 AM - 8:00 AM) seven days a week. There was no evidence that the facility conducted simulated fire drills at least four times (4) a year for each shift from June 2008 to May 2009. Review of the fire drill log book on June 10, 2009. beginning at 11:43 AM, revealed that only two drills had been held during the morning shift (on January 4, 2009, at 9:45 AM and January 5, 2009, at 8 AM). Further review of the fire drills ravealed there no drills were conducted from June 2008 through August 2008 during the 4 PM to 12 AM shift. Interview with the QMRP acknowledged that the drills were not conducted quarterly on each shift. 483.470(i)(1) EVACUATION DRILLS W 441 W 441 Provider disagrees The facility must hold evacuation drills under with this deficiency. varied conditions. Varied Conditions were This STANDARD is not met as evidenced by: used as stated in the Based on staff interview and record verification. the facility falled to use different escape routes findings. The standard during fire drills for seven of seven clients residing stated is incorrect as In the facility. (Clients #1, #2, #3, #4, #5, #6, and #7) the facility and in fact The finding includes: use different escape routs

On June 10, 2009 at beginning at 11:43 AM.

during the five dills. Using

PRINTED: 06/20/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 090112 08/12/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GODE 1226 LAWRENCE STREET, NE WHOLISTIC 02 WASHINGTON, DC 20017 PROVIDERS PLAN OF CORRECTION (BACH CONNECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) (X4) ID PREFIX ID PREFIX TAG COMPLETION TAG DEFICIENCY W 441 Continued From page 11 W 441 review of the facility's fire drill record revealed that tour out of five most of the fire drills were conducted via the methods of egress is back, front, side door, and the second level fire mects escape. On June 12, 2009, observations of the environmental walk-thru and interview with the the stundards delineated House Manager revealed there were five (5)

W 454

the basement almost daily for exercising on their treadmills. The HM acknowledged that the basement was not used as an escape route during fire drill evacuations.

W 454 483.470(I)(1) INFECTION CONTROL

The facility must provide a sanitary environment to avoid sources and transmission of infections.

methods of egresses. Further review of the fire drill records revealed that the exit to be ment

had not been used at any time. Interview with the House Manager (HM) revealed that clients use

This STANDARD is not met as evidenced by: Based on observations and interview, the facility felled to ensure that each staff prepared food in senitary conditions at all times for seven of seven clients residing in the facility. (Clients #1, #2, #3, #4, #5, #6, and #7)

The finding includes:

On June 10, 2009, at 3:14 PM, a pack of chicken was observed thawing out inside the kitchen sink with warm water running over it. The Qualified Mental Retardation Professional (QMRP) was made aware this issue an immediately turned the water from warm to cold white the chicken continued to be thawed out inside the sink. The QMRP acknowledged that staff should run cold water over the chicken. There was no evidence that the facility maintained a senitary environment

Steff will be inserviced on time and
temperature control as
well as acceptable
methods of thawing
food. Pleuse find
affacted an outline

of the in-service

in the regulations.

7/1/09

PRINTED: 08/20/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (23) DATE SURVEY COMPLETED A BUILDING S. WING 09G112 08/12/2009 NAME OF PROVIDER OR BUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1226 LAWRENCE STREET, NE WHOLISTIC 02 WASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) (X4) ID PREFIX PREFIX TAG PROVIDER'S PLAN OF CORRECTION (715) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 454 Continued From page 12 W 454 to avoid sources and transmission of infection.